

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED AUG 19 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

25714

Registration District No. 608

Primary Registration District No. 5-807A

Registrar's No.

81

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Stella
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Cardwell
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 10 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Donald Richard Duncan

3. (b) If veteran, name war ----- 3. (c) Social Security No. ---

4. Sex M Color or race W
5. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ----- 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased Sent. 10 194D
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 10 10 hr. min.

9. Birthplace Wheaton Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business -----

MOTHER FATHER { 12. Name R. E. Duncan
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Marie Rhone
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. E. Duncan
(b) Address Fairview, Mo. R#
17. (a) Burial (b) Date thereof July 22-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rockycomfort Mo.
18. (a) Signature of funeral director Wm. H. Jones
(b) Address Wheaton, Mo.
19. (a) 8-2-1941 (b) Lida Colling
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ---
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st
year 1941 hour 4 minute 15 A.M.
21. I hereby certify that I attended the deceased from July 1
1941 to July 21 1941;
that I last saw him alive on July 20 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Meningitis Duration 2 days

Due to Whooping Cough 4 weeks

Due to 9

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury

23. Signature John R. Ellison (M. D. or other) 2 Do.
Address Wheaton Mo Date signed July 24

RECEIVED

District Health Officer No. 6;

District File Number 841-1395

Date Filed AUG 15 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Wm Morris Rogers

Licensed Embalmer No. 3942

P. O. Address Whitman Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25714
Registrar's No. 31

Registration District No. 608

Primary Registration District No. 5807

1. PLACE OF DEATH:

- (a) County newton
(b) City or town stella
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Cardwell 2 days
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 10 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Donald Richard Dunean
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 8
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 10 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County newton
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 24 Year 1948 Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

- Immediate cause of death _____ Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

